AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION - HEALTHY INDIANA PLAN

State Form 53405 (10-07) / HIP 2514

The information collected in this document is confidential pursuant to 470 IAC 1-2-7, 470 IAC 1-3-1, 42 CFR 431 Subpart F, and 45 CFR 164 Subpart E.

Name of applicant	Case number	Due date for your response (*month, day, year*)

Please sign and return the Authorization for Release of Medical Information below so that we can continue the processing of your application for the Healthy Indiana Plan (HIP).

Based on your answers to the Health Screening Questionnaire, the Enhanced Services Plan (ESP) may be the HIP health plan that will best suit your needs. If you are determined eligible for HIP, you will be enrolled in the ESP. The ESP assessment team will then obtain copies of your medical records from the medical providers you listed on your HIP application. These records will be reviewed to determine if the ESP is appropriate or you.

If we do not receive your signed release by the due date specified above, your HIP application will be denied. Return your signed release to: FSSA Document Center, PO Box 1810, Marion, IN 46952; or fax it to the Document Center at (800) 403-0864.

If you have any questions, please call (800) 403-0864.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize and direct the medical provider named below to release my individually identifiable health information to the Indiana Family and Social Services Administration (FSSA), including companies and persons it contracts within the administration of the Healthy Indiana Plan (HIP). Information concerning my medical care, treatment, or advice including medical or other care records, diagnosis, pharmacy information, information about HIV or AIDS, as deemed necessary by FSSA to determine my eligibility for benefits under the HIP Enhanced Services Plan and to administer benefits under the plan may be released.

I further authorize that a photocopy or fax copy of this medical release may be used to obtain the information requested.

I expressly consent to the release of my Social Security Number.

I understand that this information is protected under Federal and State confidentiality and privacy regulations and cannot be disclosed without my written authorization unless otherwise provided for under the law.

I understand that I may revoke this authorization at any time in writing, but if I do, revocation will not affect any actions already taken or uses or disclosure made before the revocation.

This authorization will expire fourteen (14) months after the date of my signature below or as long as I am covered under the plan, whichever is later, unless revoked by me.

Signature of applicant		Date of signature (*month, day, year*)
Printed name of applicant	**Date of birth (*month, day, year*)**	**Social Security Number**
Name of provider		**Telephone number of provider**
		( )
Address of provider (*number and street, city, state, and ZIP code*)		